Attaining the "Health for all" commitment. Which model for health insurance ? Some lessons from the European and USA experiences

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Abstract

In 1998 the Fifty-first World Health Assembly passed the "health-for-all policy for the twenty-first century". During this assembly the Member States of the World Health Organization (WHO) reaffirmed their commitment to the principle that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being”. Even if there is now a worldwide consensus that health insurance plans should cover the whole population to attain the highest standard of health, a question still remains unsolved. What kind of health insurance coverage is the most likely to attain this goal efficiently? European countries are frequently cited as exemplary for the high level of health attained by their population, while sometimes very different health insurance models are implemented today in these countries. This paper discusses the advantages and shortfalls of the different options, for health insurance and population coverage that have been chosen in Europe. Four topics are treated successively: the choice between private and public insurance, how to guarantee the balance between revenue and expenditure? What should be the basis for health insurance payment? And finally should health care services be totally free of charge for the patients?

Introduction

By the late nineteenth century most developed countries had created some kind of health insurance system. Usually mutual aid societies were shaped for some categories of workers. The health insurance coverage for the whole population has been one of the main objectives of European countries after the World War II. Progressively, they reached this goal, even if health insurance still remains fragmented in some countries or has been only recently completed (for example, in 2000 for France, when the act establishing Universal Health Care Coverage set out the right to health insurance for all residents). The US implemented limited universal coverage mechanisms in the sixties to cover the poor (Medicaid) and the elders (Medicaid) (Cutler, 2002). Nevertheless, the percentage of US citizens without health insurance coverage rose and universal coverage is now on Obama's agenda.

In 1998 the Fifty-first World Health Assembly passed the "health-for-all policy for the twenty-first century". During this assembly the Member States of the World Health Organization (WHO) reaffirmed their commitment to the principle that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being"..

There is nowadays a worldwide consensus that health insurance plans should cover the whole population to attain the highest standard of health. Universal coverage means protection for all citizens and legal residents against the catastrophic expenses due to illness and injury. These schemes have not only been developed on an utilitarian purpose (i.e. population should have a minimum coverage to prevent infectious diseases or to produce more efficiently), but also on a more humanitarian view, which is based on the assumption that it is not fair or ethical to let the poor or the old people be uncured, just because they don't have enough money to pay for a doctor or a hospital stay. Medical care is thus perceived as a human right.

To date one question still remains unsolved. What kind of health insurance coverage is the most suitable to reach this goal efficiently? Multiple health insurance models are used today in the world. As European countries are frequently cited as exemplary for their high level of health attained by their population, this paper, based on published literature analysis, discusses the advantages and shortfalls of the different options for health insurance and population coverage that have been chosen in that part of the world. Answers to four questions: choosing between private and public insurance? How to guarantee the balance between revenue and expenditure? What should be the basis for health insurance payment? And finally should health care services be totally free of charge for the patients? This article is successfully examining these questions.

Choosing private or public insurance for health ?

To cover health care risks, the advantages of the model relying on pure private health insurances in competition and its traditional failures are well known. Private health insurance allows people to self-finance their own health needs. The consumer believes that he has a great choice between several insurance plans, and thinks that his preferences are taken into account.

But this ideal picture has several drawbacks. The insurer spreads risk among many insured people and calculates the actuarial fair rates for premiums. Competing health insurers usually adopt risk rating and charge higher premiums to individuals likely to be at greater risk of using health services. Thus, people with chronic illnesses, the handicapped or the elders will have to pay higher premiums than the rest of the population, even though they have a lower income or purchasing power. If the insurance is optional, the poor or high-risk people will not subscribe any insurance. To increase its profit, the insurer develops risk selection and segmentation that could endanger the “health for all” principle.

Moreover, for the insured, freedom of choice is often an illusion insofar as health insurance contracts are usually very difficult to understand and insurers deliberately make them complex to limit the comparison possibilities.

One solution could be to fill the gap due to "market failures" by proposing a public insurance only for the poor, the elders or people with chronic illnesses and a private one for the others. This has been implemented during the sixties in the United States through Medicare (for old people) and Medicaid (for poor people) federal plans.

In that case, the bad risk is publicly financed, while the "good" risk is covered by the private insurers. But all insurers should be able to balance good and bad risks to attain budget equilibrium. This principle is also true for public insurance. Left to public insurance, the bad risk on health should then be structurally subsidized by taxes or private charity with high probability of being underfinanced.

Public insurance

Compulsory unique public insurance may be another solution. France and UK have public health insurance in monopoly; for France it is mainly financed by social taxes (Bismarkian model) while, for UK, income taxes are paid (Beveridgian model). Both countries are thus organizing solidarity on a national basis. With a large and mandatory enrolment, a unique public insurance is more efficient in risk pooling and could be able to achieve cost containment by using a monopsony power.

Nevertheless, this model has all the disadvantages related to public agencies with bureaucracy. Numerous and often contradictory instructions (changing at each election) are issued from the central power. According to Le Grand (2006), it does not motivate providers, especially when they are used to a high degree of autonomy and trust. Capture of power by

stakeholders or lobbies, such as doctors or pharmaceutical industries for example, is another risk. They thus negotiate, with the government or the social insurance administrators, high fees for service payments or prices. This risk is higher when, like in France, numerous doctors are also members of the Parliament. It could be incompatible with the insured or payers (citizens, employers or employees) interests.

For this reason the United Kingdom implemented reforms in the nineties introducing competition and contracts via quasi-markets (Koen, 2000) for providers (see graph 1). Hospitals and the other providers were corporatized as semi-independent "trusts" contracting annually with the National Health Service. Those reforms were very recently introduced in France (a first introduction in 1996 reinforced by a new reform for hospital payment in 2005 and the creation of regional health agencies planned for 2010). The separation between providers, purchasers, and the contract process has the advantage of bringing a greater clarity on standards and prices. It allows health providers to acquire cost-consciousness and thus contributes to cost reduction. But it is not so clear that the quasi-market could lower the overall costs, because health care professionals get a tendency to discharge patients to others (early discharge from hospitals to home care settings for example). This model encourages also segmentation between primary care providers and hospitals, while an integrative scheme is better to ensure the medical follow-up of the patient. Moreover, since contracts imply negotiation, administrative costs increase. Competition remains structurally limited, because patients have often a restricted choice of hospital or specialist within their geographic area of living.

Finally, for these two countries, competition is limited to the health care providers (see figure 1), while health insurance still keeps its monopoly for financing health care providers, and patients do not have any choice for their social health insurance.

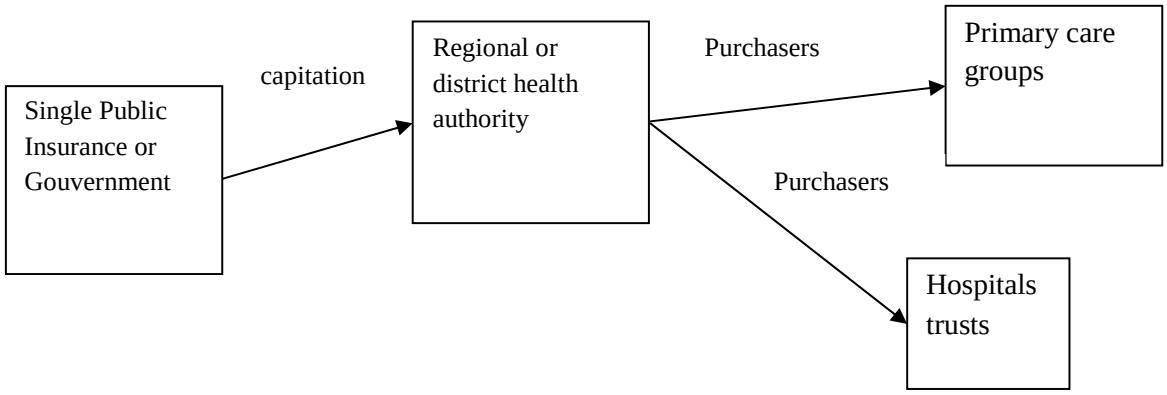

Figure 1*:* Competition with "quasi-market" contracts in UK

The managed competition solution : By using the "managed competition" model developed by Enthoven (1993), choice for health insurance was implemented in several Northern European countries (i.e. The Netherlands, Germany, Switzerland). When people have a preference for pluralism in health plans and individual choice combined with universal coverage, this organisation scheme is supposed to be more efficient than unique health insurance.

In managed competition what Enthoven calls "sponsors" plays a central role. A sponsor is an agency that contracts with insurers in competition concerning covered benefits, prices, enrolment procedures and other conditions of participation. The sponsor establishes rules of equity: health insurance is usually mandatory and insurers can't deny coverage to new applicants (in order to avoid the adverse selection problem). It guarantees the freedom of choice for the patient, comparability of insurance plans (a minimum package of benefits is defined and must be provided by all insurers), a common regulatory framework and quality of care. Instead of directly paying providers to deliver health care, the sponsor finances the insurances in competition (see figure 2).

Insurers (Sickness Funds-SF) are divided in each community into competitive economic units. Market forces are used to motivate them in order to develop efficient delivery systems. SF can integrate financing and provision of care (the insurer is the owner of a hospital for example) but also the use of contracts negotiated annually with health care providers. Contracts generally combine fee for service with capitation or by results payments (for prevention activities for example). So the SF has a bargaining power with health providers. Doctors should be motivated to prescribe economically. Strong disease management programs can exist. For example, SF in the Netherlands can decide if a medical problem should be treated by a specialized nurse or by a doctor.

The insured choose on an annual basis the SF that minimizes the total cost with a predefined benefit package. This system is usually accompanied for them by a limitation of choice of the doctor (i.e. preferred provider networks).

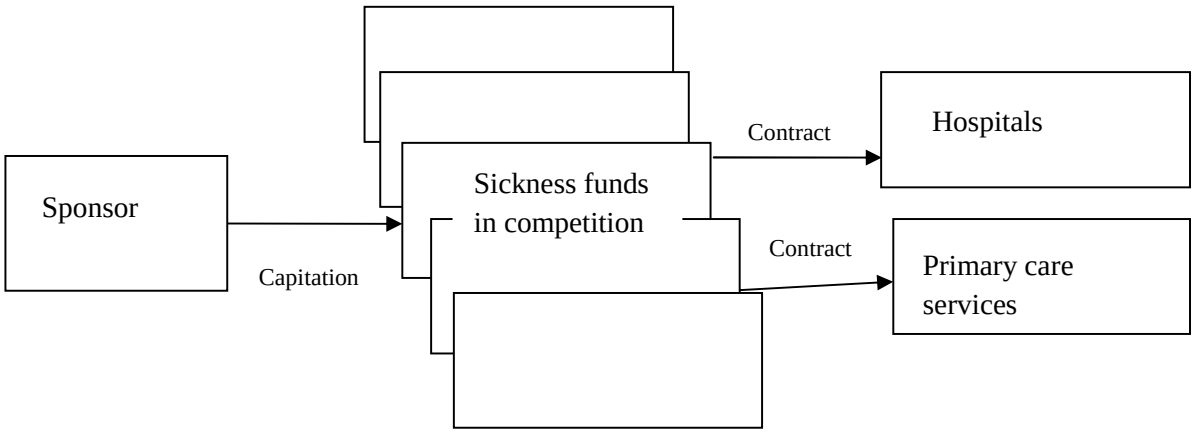

Figure 2 : Managed competition

Sponsors could be the employers which negotiate insurance contracts for their employees. Health insurance premiums are shared between the employees and the employer or paid wholly by the employer. This solution is the most obvious for firms who want to rely only on

themselves for social coverage and to guarantee a good level of health for their employees. It could be efficient from the company point of view, but it has proved its limitation on a systemic or national level, because small firms usually do not have the capacity to offer health plans to their employees and self employed people are not covered. The health plan generally stops when workers retire, because firms are not able to guarantee a long term health insurance. There is no portable coverage; the health guarantee lasts one year, and the employee loses his health insurance when leaving the company. This could be problematic for chronically ill workers and thus reduce job mobility (Goodman, 2006). So sponsors should preferably be independent of the job status.

For this reason sponsors are more often local or central governmental agencies or a central social health insurance (depending on how health is financed, i.e. taxes or social contributions) which centrally collect money, assume fund pooling and distribute it to insurers with pre-defined criteria (see table 1).

Table 1: sponsors and insurers in countries which have implemented with managed competition

Country, source	**Sponsor**	**Insurers in competition**
USA (Menzel, 2008)	Federal employees health benefits plan	Competing private companies
Netherlands (Bartholomée, 2006)	Government	Health insurers (private or non profit)
Germany (Mosebach, 2006)	The federal government	Competing sickness funds
Switzerland (Beck, 2003)	Cantons i.e. local health authorities	Competing sickness funds (non for profit for basic package)

In the Enthoven's model, it is theoretically possible that public, private for profit or non for profit insurers compete on the same health insurance market. In the Netherlands for example,

health insurers may operate on a profit basis. The debate usually focuses on public/private competition. But in several countries for-profit stock companies and non profit mutual companies coexist. Mutual insurance is a form of risk pooling between groups of homogenous members. They are associations voluntary dedicated to the purpose of providing their members with financial assistance in case of need. Members ex-post share the losses so they are motivated to control moral hazard problems. Mutual companies return surplus to the insured. Pure insurance companies have a more heterogeneous clientele with no specific internal control by the group.

Where several insurance programs are operating on the health market, the implementation of a managed competition model could be a solution to standardize health benefit packages and increase efficiency.

The resource allocation criterion

In managed competition, the revenues for health care provision are centrally pooled in a federal or national fund. An amount of money, generally consisting of a per capita payment, plus risk adjusted extra payment balancing the differences of risk structures between SF, is paid to individual sickness funds, in order to encourage “fair competition”.

But the drawback is that when pooled revenues are not sufficient to cover their expenses, the insurers can charge an out of pocket payment to the insured. It could be income related or flat-rate. In Germany for example, this amount is capped to a maximum of 5% of the overall health care cost and additional charges are limited to a maximum of 1% of the income of the insured (Mosebach, 2006). This raises the question of compensation for sickness funds with an unfavorable risk structure (insuring many people with chronic diseases or low income). If those sickness funds charge more their members, some may opt out and choose another

insurer and the SF may go bankrupt or have to merge with its competitors; the number of sickness funds in competition will thus get lower and lower.

On the contrary, if the sponsor decides to integrally compensate the losses of SF with higher risks, it should be perfectly informed on the risk profile of each insured person, to be able to only compensate the risk level and not also the inefficiencies in SF management. But it is often not possible, because there is usually some confusion between efficiency and risk management and the sponsor is not perfectly informed.

Mutual insurance could be an efficient means of addressing contract challenge. They are usually able to offer lower fees than pure insurances propose and are able to solve managing monitoring problems. According to Born (1998), mutual companies are more interested in making insurance available and affordable since their policyholders are also owners. They offer more prevention services as they are on a long-term relationship with the insured. Nevertheless, empirical studies that prove these assumptions are lacking.

The issue of fair resource allocation remains also problematic for countries with a National Health System because of determination of fund allocation to localities. As an increasing number of health care systems are becoming decentralized and community-based health insurance is popular, the question of allocation to local authorities is of course emerging with a strong acuity.

In Europe, systematic funding formulae have been used for determining local budgets. UK was the first to implement a risk based allocation (it dates from 1976 and is called the Resource Allocation Working Group –RAWP- formula). The RAWP formula (Smith, 2008) used the principle of weighted capitation where the local budget depended on population size, age and sex, mortality ratio of the locality; an adjustment was made for variation in the input

prices of local services. The formula had been progressively completed by health inequalities variables (long standing illness ratio, unemployed, pensionable age living alone, single-career households). The health inequalities adjustment was nevertheless withdrawn in 2003.

Capitation formula creates an insurance risk pool and the central power has to ensure that the expenditure is in line with the expected expenditure on a population with certain characteristics. They have to find out a formula that tries to approximate as closely as possible individual variations. But they also have to take into account practices of local providers, geographical information (numbers of kilometers to see a doctor for example) and a random parameter (unpredictable incidence of illnesses).

For Okma (2001) criteria need to be objective and easy to collect (age, sex, region, and if possible socio-economic and medical status). Nevertheless, a prospective regulation formula will never be perfectly adjusted to real level of risk and expense. Thus cross subsidiaries possibilities should be left locally to health producers or sponsors, insofar as they better know patients' needs than the regulator and ex post compensation arrangements with extra money allocation for extra costs should be possible. The formula supposes that the global budget is sufficient to cover health care needs of the population; it implicitly means that there is no unmet need, and that the regulator only has to solve a resource allocation dilemma. Moreover, giving more money to a region with high unemployment does not guarantee that the poor will use more health services.

In Europe, the management of the appropriate local health services remains unsolved. Several countries are still facing waiting lists (for elective surgery for example) due to problems of local management of supply and demand.

How is the balance between revenue and expenditure guaranteed?

To guarantee the balance between resources and spending, policymakers have to pay careful attention to how they allocate resources and what payment scheme they should implement to contain costs.

Global budget capping : Global budget caps are therefore viewed as the central instrument to slow the growth of health spending (Van de Ven, 1995). Government usually starts to determine global budgets for the entire category of public spending and then specify the amounts for each category of spending.

For example, in France, since 1996, a yearly National Objective for Health Insurance Spending (ONDAM) is voted by the parliament. It is an annual ceiling for overall public health insurance expenditure which can be viewed as a prospective spending limit, devoted to public health care provision. Once the overall budget is set, it is divided into four sub-groups representing categories of spending: outpatient care (i.e. general practitioners, specialists, nurses, drug delivery, dentists, and physiotherapists), public hospitals (divided in 22 regional sub-budgets), private for-profit hospitals and care for handicapped and elderly people. Each of the sub-groups has its own target level and, for outpatient care, each professional category has to adjust its own spending to its target level. A different spending growth rate is attributed to each sub-group, by considering if the sub-group exceeded the target the year before or not, and by evaluating new public health objectives.

With such a “cascading model” the sub-groups budgets are usually more controversial than the global ones, because they directly allocate the revenues of health care professionals. The question of capitation methods used by insurers or local government agencies to pay units such as hospitals or health centers has emerged. Diagnosis or case payment is now developed

in the USA and some European countries. But the incentives for health producers to cream skim are high for patients whose expected expenditures are higher than for the capitation payment.

Those sub-groups budgets are not only a matter of objective allocation criteria, but reflect also the interaction between the State and the stakeholders. In France for example if physicians spending exceeded their global budget, they were supposed to reimburse the Public Health Insurance. But in 1998 they refused to do so. Physicians even turned against the Health Insurance system, by bringing legal action before the Council of State and in front of the Constitution Council to denounce reimbursement agreements. These judicial bodies ruled in the physicians' favour. They motivated their decision by the illegality of the reimbursement procedure. Physicians were considered as collectively responsible and each of them had to pay a fixed amount in proportion of the overall exceeding; so everyone in the group was punished for what could be interpreted as the excesses of only some of them. This was considered as incompatible with the French constitutional principles. After 1998, price flexibility was moderated by providers' negotiations. Fees were not automatically reduced when expenditures exceeded this target.

For the regulator of global budgets, finding an arrangement with local producers, especially independent physicians, is always difficult, even in countries that have implemented managed competition.

In the United States for example, a Sustainable Growth Rate (SGR) (GAO, 2002 and 2005) system was created by the Balanced Budget Act of 1997. Its objective is to moderate spending of Medicare, the federally financed program for the elderly. Over time, the SGR system has been revised but its main principle remains. When physician services exceed a pre-defined spending target, fee updates are reduced. Thus increases in spending caused by volume are

corrected by fee moderation. The SGR is the product of the estimated percentage change in four elements: (1) input prices for physician services, (2) the average number of Medicare beneficiaries in the traditional fee-for-service (FFS) program, (3) National economic output, as measured by inflation-adjusted GDP per capita (4) expected expenditures for physician services resulting from changes in Laws or Regulation.

A close mechanism was also implemented in 1993 in Germany (Benstetter, 2006). Health care reform legislation strengthened the global budgeting of physicians. German physician expenditure was capped, thanks to a point-system. At the end of each quarter, the global budget for all physicians is divided by the sum of points submitted by all physicians for reimbursement. Nevertheless, if volumes of care are steadily increasing, the point value drops and there is a risk of physicians' bankruptcy. This problem could be solved if physicians are guaranteed that the fee value could not fall below a pre-determined value.

A soft regulation process based on "mutual confidence" could also emerge locally. The local public Health Insurance authorities sit down with producers to adopt a regulatory approach that is acceptable to them. Contract terms usually balance an upper level for fees with changes in prescription patterns (e.g. less drug prescriptions, less home visits by physicians, more prevention etc.). Setting budgets for physicians or hospitals is no longer choosing quantitative criteria and applying financial penalties but a matter of interaction between public health insurance and stakeholders. Thus physicians are supposed to adopt self-regulation and virtuous behaviour. But whatever the merits of a regulatory procedure based on ethical codes and good professional practices, it is doubtful that this strategy will be successful without introducing an efficient tool to regulate the overall spending. Historically, physician self-regulation has not been particularly successful in controlling the behaviour of individual physicians nor in France neither in other countries (Jacobson, 2001). Indeed, there is no

substantial evidence of physicians' ability to respect their contract, even on key points (e.g. generic drug prescriptions are often lower than the level recommended in the agreements).

The method of budget capping has the advantage of recognising that health care provision should be compatible with the GDP per capita growth rate. As health care is often financed by taxes on the gross national revenue, this is a coherent way to link health spending growth to the overall wealth of the country.

Consequences for long term planning: Anyway, planning expenditure is a difficult exercise. Spending for the following three or five years seems to be a maximum if one wants it to be realistic. On a long term basis, physicians consider that demand structurally increases faster than the GDP growth rate. This is due to the ageing and to the dynamic of medical technology. To cover health care needs, the SGR system's allowance should be increased regularly. So the regulator must deal with the issue of whether future health care can be publicly financed. There are three possible options:

- Reducing the package of care which is financed through public funds. For example, France is cutting the list of drugs that are reimbursed. As a consequence out-of-pocket and private insurance payments will increase. They already represent 23.4% of overall health care spending in France. This solution is acceptable if the publicly financed health care basket remains accessible to the whole population and is of good quality.
- Reducing prices is now often presented as the main regulatory tool. For hospitals the chronology of payment mechanisms seems to be everywhere the same. Global budgets firstly replace fee for services payment. Secondly case payment (using Diagnosis Related Groups) is introduced. In France, health authorities introduced an annual global budget for public hospitals in 1983. It was also successful in

slowing hospital expenditure growth rate, which passed from an annual average rate of 8% before 1983 to 4% thereafter. But, according to numerous European health authorities, a better way to reduce costs is per case payments through Diagnosis Related Groups (DRG). The DRG classification has thus progressively been replacing hospitals' global budgets. From now on, if all public hospitals exceed the overall sub-budget devoted to hospital activities, DRG unit prices will be reduced in the following year. However, lowering prices too much can discourage health professionals. The temptation for physicians in Germany is the opting out solution, by joining the private sector financed by private insurance.

- Increasing taxes and accepting that health care will be a major part of public finances in the future. WHO members states recognize that "the improvement of the health and well-being of people is the ultimate aim of social and economic development". Allocating more money to health care and presenting this allocation as a final result (replacing the GDP growth) could be a solution to tackle this financing issue, even if it is still important to evaluate whether the services bought are worth the money that is spent on them.

Even if the two first options are widely used in Europe nowadays, there is no doubt that the third one will be considered with a stronger acuity for next decade.

What should the basis for health insurance payment be?

Health insurance, as all insurance systems, should enable monetary transfers from low-risk to high-risk individuals. A large fund pooling is a necessity from a risk management point of view but who should pays and on which basis?

The limited role of out of pocket payment : European countries finance their health care through a mixture of income taxes, social insurance contribution, private insurance premiums and out-of-pocket payment. It is usually considered that out of pocket payment should be limited as much as possible because it is equivalent of a non existence of insurance market as there is no risk pooling and because patients are bearing the entire financial burden when they become ill while their revenues are getting lower. Health expenditure should be pre-financed (i.e. before the risk occurs) and no European countries, except Greece, is longer relying on more than 26% of co-payment to finance its health care system (see table 2).

Table 2 : Out of pocket and private health insurance as a share of total health expenditure, 2007

	Out-of-pocket	Private health insurance	Sum
Luxembourg (2006)	6.5	1.7	8.2
Netherlands	5.5	5.7	11.2
United Kingdom	11.4	1.1	12.5
Czech Republic	13.2	0.2	13.4
Norway	15.1		15.1
Denmark	13.8	1.6	15.4
Iceland	16	0	16
Sweden	15.9	0.2	16.1
Japan (2006)	15.1	2.6	17.7
Ireland	9.9	8.1	18
New Zealand (2006)	14	5	19
Turkey (2005)	19.9		19.9
Austria	15.4	4.6	20
France	6.8	13.4	20.2
Finland	18.9	2.1	21
Italy	20.2	0.9	21.1
Germany	13.1	9.3	22.4
Belgium	18.3	5.4	23.7
OECD	**18.2**	**5.7**	**23.9**
Poland	24.3	0.5	24.8
Australia (2006/07)	18.2	7.5	25.7
Hungary	24.9	1.1	26
Slovak Republic	26.2		26.2
Spain	21.1	5.9	27
Portugal (2006)	22.9	4.1	27
Canada	14.9	12.8	27.7
Greece	39.7		39.7
Switzerland	30.6	9.2	39.8
Korea	35.7	4.1	39.8
United States	12.2	35.2	47.4
Mexico	51.1	3.7	54.8

Source : OECD Health data, 2009

Using taxation with redistributive effect : Rather than using risk adjusted premiums, European countries introduced a redistributive effect for health care financing. The redistributive effect is desirable when considering equity, because health expenditure is concentrated among lower socio-economic groups (De Graeve, 2003) and because in almost

all countries, the income gap is getting wider among people. In the European region, income poverty has spread from a small part of their population to about a third (WHO, 1999).

Even if taxation modalities are heterogeneous, they are thus linked to income in most European countries. Using an income tax for financing health care is thus viewed as a fair way to redistribute wealth between people. It has been proved (De Graeve, 2003) that among financing means used to pay for health care, direct taxes or social insurance contribution are progressively distributed and thus contribute to a vertical redistribution in Europe (from high to low incomes). Even though, some countries (Germany and the Netherlands) register a regressive effect from health-related social insurance due to the introduction of opting-out possibilities for high-income earners, who prefer to take private insurance. Out of pocket payments are regressive in all European countries while the result for private insurance is not so clear when this private insurance is a complementary or supplementary one. In that case, it depends on how premiums are calculated (flat premiums or gross income premiums). For example, it is regressive in Belgium and France, because non for profit complementary insurances called “mutuelles” are charging a flat premium.

Table 3 : Kakwani indices of the financing sources of health care in Selected European Countries.

	Public Finance				Private finance			
Pays	Direct taxes	Indirect taxes	Social insurance	Total insurance	Private insurance	Out of pocket	Total private insurance	Total
B (1997)	0.180	-0.180	0.102	0.061	-0.210	-0.260	-0.250	0.000
DK (1987)	0.062	-0.113		0.037	0.031	-0.265	-0.236	-0.005
FIN(1994)	0.087	-0.106	0.123	0.066	0.000	-0.198	-0.198	0.050
F (1989)	-	-	0.111	0.111	-0.196	-0.340	-0.305	0.001
G (1989)	0.249	-0.092	-0.098	-0.053	0.122	-0.096	-0.007	-0.045
IRL (1987)	0.267	na	0.126	-	-0.021	-0.147	-0.096	-
I (1991)	0.155	-0.114	0.107	0.071	0.171	-0.081	-0.061	0.041
NL (1999)	0.281	-0.091	-0.094	-0.060	0.073	-0.074	0.015	-0.035
P (1990)	0.218	-0.035	0.185	0.072	0.137	-0.242	-0.228	-0.045
E (1990)	0.213	-0.153	0.062	0.051	-0.022	-0.180	-0.163	0.000
S (1990)	0.053	-0.083	0.010	0.010		-0.240	-0.240	-0.016
CH (1992)	0.206	-0.072	0.055	0.139	-0.255	-0.362	-0.295	-0.140
UK (1993)	0.284	-0.152	0.187	0.079	0.077	-0.229	-0.095	0.051
US (1987)	0.210	-0.067	0.018	0.106	-0.237	-0.387	-0.317	-0.130

Sources : Jansen et Van Doorslaer (2002), Klavus et Häkkinen (1998), Van Camp and Van Ourti (2003), Wagstaff et al (1999) in De Graeve et Van Ourti ; The distributional Impact of Health Financing in Europe : A review ; pp. 1459-1479 Blackwell Publishing LTD.

With public financing sources, the financial burden is shared among the national population but payments are not the same for everybody. Thus the “rich” people are paying more than the “poor” ones for potentially the same level of health services. To sum up, in Europe an egalitarian approach is prevailing. That means that the distribution of health care payments should be in line with the household’s income, while consumption of health care should be related to need.

Global pooling could also be profitable to the "rich", since working with several patients (that are indifferently rich or poor) provides experience so that doctors can improve their medical knowledge and skills and thus be able to treat patients with a higher quality standard. That means that the poor and the rich would benefit from the highest technologies and the better medicine, without difference. This is particularly true for rare/orphan diseases where doctors skills depend on the number of patients seen. Nevertheless, it is only true for countries where the medium quality level of health care is high. In developing countries, the rich don't want to pay for the poor because they generally prioritize individual quality of care.

Nevertheless, payment equity is not always attained in several countries, because the income basis used is sometimes not the same for the whole population. According to VanDoorslaer and al. (1999) in some countries, households with similar incomes may pay different rates because their earnings are taxed in different schemes. This is true for France (salaried vs self-employed), Germany (rates are varying across sickness funds), Italy (rates are varying across professional groups) and Portugal (Rates are varying across occupational groups). There could be also differences due to the fact that the contribution is sometimes based on the individual income and sometimes on the household one (with no additional contribution for non earning members of the household).

European countries have also some issues to tackle such as need satisfaction because access to treatment doesn't mean receipt of treatment; equity in financial payment and equality in access do not mean equality of health. "Rich" people are still profiting more of a good health care system than "poor" people especially for prevention. Low co-payment and low taxation is thus a necessity but it is not sufficient. Using Sen's (2002) analysis, one should equalize

access that potentially allows people to have the same capabilities or functioning. European countries do not have attained this goal yet.

What are the health benefits offered to the population ?

Heterogeneity in insurance plans and prices are often encountered in European countries. This shows that "health for all" does always mean equality or homogeneity for everybody.

Usually, countries have created a list of health benefits (health insurance package) that is compulsory and included in all the insurance plans, but prices and extra services can differ from one insurance plan to another. A complementary voluntary plan covers additional health services such as physiotherapy, dental care for adults, psychotherapy and preventive care. Efficiency is supposed to be attainable thanks to the insured that choose the insurance plan where they can get the best value for money. Consumers are supposed to vote with their feet if insurers do not fulfill their expectations. But in reality consumers have difficulties to make informed choices and websites have to be built to provide information comparing health plans or provider performances (usually measured by waiting time or patient satisfaction but not by medical performance) (Bartholomée, 2006). In Switzerland for example, the range of variation between premiums is large but the insured are not moving to "the best value for money plans" (Beck, 2003). Information seems to be better on mandatory health plan than on supplementary one. Changing of insurer generates administrative work for the insured.

Creating the temptation of segmentation. When resources are limited, separating high risks from low risk in two different insurance plans is a great temptation. Private insurance or households are thus supposed to pay for the low risk while public insurance pays for the higher risk. This solution was implemented in the Netherlands before 2006 and recently the French government wanted to put an end to public reimbursement for dental and optical care, leaving them totally to complementary insurers.

As many people prefer to have their complementary insurance and basic coverage in the same sickness fund, health insurers could deny the complementary or supplementary insurance access to poor or sick people in order to discourage them from purchasing the basic health plan. So the division between basic and complementary benefits package could not be compatible with equity and solidarity and thus to the “health for all” objective.
People with low incomes will be the first ones to suffer from cuts in the health benefit package as they are not able to buy a complementary health plan.

This risk segmentation has other drawbacks. The first one is that a low risk individual can become a higher one if he is not cured in time. If people have to pay for their family doctor or other primary care services, they can postpone a medical visit and their pathology can be more complicated to treat several weeks later leading to hospitalization and higher costs for the public insurance.

The other disadvantage is that young people are usually not confronted to high risk, because they are in good health. Therefore, if they do participate in the financing of the public insurance (used by the elders), they will have the sensation to pay taxes without benefiting from public health services. They will thus be more willing to opt out this payment whenever possible.

In conclusion, dividing low risk from high risk should not be recommended. Health insurance should thus be considered as a whole. It could exclude some health benefits but those should be considered as optional because they are more linked to comfort than belonging to the core of health care supply.

The role of voluntary insurance

Two options for voluntary insurance have been chosen for limiting direct out-of-pocket payments. They are both creating a “double insurance” phenomenon.

The first option is “complementary voluntary health insurance”; that is full or partial coverage for services that are excluded or not fully covered by the statutory health care system benefits. It provides coverage for the reimbursement of co-payments in Belgium, Denmark (pharmaceuticals only), France (ambulatory care and limited hospital co-payment), Ireland (outpatient care) and Luxembourg (hospital co-payments). Combining public and private insurance for the same population is nevertheless not often used in Europe. France is an outlier in this respect, with a financing of complementary insurance equal to 13% of the global expenditure.

The second option, is medical saving accounts that emerged first in Singapore (known as Medisave) (Hsiao, 1995). They are based on the principle of self-reliance and individual accountability. Citizens are required to save a proportion of their income every month. MSAs are a compulsory individual contribution for health care. MSAs encourage uninsured people to purchase insurance, especially when they are tax deductible. Even if policy analysts have considered its applicability in United Kingdom for example, they are not yet considered in Europe as a means of financing health care.

Should health care be totally free of charge ? Before the 1970s, in Europe, medical systems were extremely generous in health services package and introduced low cost-sharing (Cutler, 2002). The government paid around 76% of the total health expenditure and deductibles were very limited. As medical spending increased the burden on the public sector grew.

Cost sharing modalities (see table 5) have been progressively introduced and European countries are now going to the direction of decreasing public share and increasing private share for financing health care.

Table 4: Cost sharing schemes used in Europe

Cost sharing schemes	Mechanism
Co-payments	The amount that the health consumer must pay out of pocket for a particular service. It must be paid each time a particular service is obtained (example €1 per physician visit).
Coinsurance	The insured person, when the event occurs, should pay a percentage of the costs. This percentage is called the coinsurance rate (example 30% of the global cost).
Deductible	The deductible is an amount that is not covered by the insurance provider. In a sense, the insurance does not apply until the consumer pays the deductible (example for an expenditure of less than €400 per year, the consumer has to pay all the expense).
Ceiling prices	Insurance is paying at a defined price, if the consumer wants a service with a higher price, he should pay the difference (example the insurance pays only the price of generic drugs and not brand name drug).

Cost sharing is not necessary bad, especially when doctors receive fee-for-service and have the temptation to practice induced demand (demand is driven by supply). Co-payment introduces consciousness for health care costs and limits the moral hazard behaviors from doctors and patients.

But out of pocket payments should not be used as an adjusting variable for balancing expenses and revenues of the health care system (increasing cost-sharing reduces government spending). If so, a system for limiting direct co-payment should be implemented. Otherwise co-payment could be not compatible with the "health for all" objective. That means that out-of-pocket payment level should remain affordable for patients. As out-of-pocket health payments exacerbate poverty, it is important to set a ceiling for them (i.e. a maximum percentage of the income) and a guarantee against catastrophic payments. The WHO in its world health report 2000 developed a measure to evaluate the fairness of health care financing; Poor households should not pay a higher share of their discretionary expenditure

on health than richer households and all households should be protected against catastrophic financial losses related to bad health (De Graeve, 2003). Considering that health expenditure is catastrophic when it exceeds 40% of income after subsistence needs have been met, Xu (2003) showed that the proportion of households confronted to catastrophic payments could vary widely between countries. Most developed countries have mechanisms that protect households from catastrophic spending. He showed that only Portugal, Greece, Switzerland and the USA had more than 0.5% of households facing catastrophic payments. However catastrophic payments are not always due to a high amount of money paid by the household. It is often linked to poverty and a lack of risk pooling. The health insurance should be designed to protect households from catastrophic spending; that means that a ceiling should be determined and it should be linked to income. For Xu (2003), if the share of pocket payment can be reduced to a maximum of 15% of total health spending few households would be affected by catastrophic payments. In table 3, eleven countries are upper. So improvement should still be done in Europe.

Conclusion

In this paper, we argued that the health insurance system which is the most likely to attain the "health for all" objective should be based on a mandatory membership and should cover the whole population. Individuals should have the option to terminate their private contracts and join the public system. Homogeneity, equity, and solidarity must be the leitmotiv of all health care systems. Homogeneity and equity could be reached through the improvement of the coverage and the creation of a standardized benefit package accessible and affordable for all, whatever health insurance they have.

Using several insurances to cover the risk seems to be better than using a public insurance in monopoly, but, in that case, the benefits package should be homogeneous, and thus defined by

a central authority. There is no evidence about what is the best status for insurers (private or mutual companies in competition, public delocalized communities …). Because of the risk of non portability, the sponsor should not be private companies but a central or local authority.

To finance health care, contributions of the households or companies should be income-related rather than flat and the most largely pooled as possible. Allocations to health care hospitals or primary care services should be based on a capitation payment formula that includes demographic (age and gender), medical (long standing illness ratio), geographical (urban or rural) and economic (income or unemployed) data as far as possible. Determining the best compensation formula to finance insurers with unfavorable risk structure still remains an issue.

Budget capping related to GDP growth should not be associated to higher co-payment for households, especially if they have to pay more than 15% of the income. Considering that health is one of the ultimate aims of social and economic development it is rational to put more money to health (i.e. increasing the percentage of health expenditure in the GDP) but this should be linked with efficiency. Escalating costs is a big challenge. If, as explained before, managed competition could be a way to tackle the problem, this measure would be efficient if only there is a better targeting in the allocation of resources. This last issue is quite complex: fund allocation necessitates an acute knowledge of the numerous local social and economic situations of states or regions and in the States or regions. Reaching cost containment by controlling the supply side is also a solution. The reforms at work using mixed payments have shown positive impacts. However, per case Diagnosis Related Group can also be a means of containing costs and so of limiting the out of pocket payments and avoiding catastrophic medical expenditures. These strategies can be implemented thanks to the increasing revenue of taxation that should be carefully allocated. Nevertheless, to date,

quality management is not developed enough in Europe and regulation is too often limited to price and financial incentives.

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